

Pediatric Rheumatology A-M

Fax: 800-269-5493 A Carelon Company Phone: 888-292-0744 bioplusrx.com/therapy Ship To: □ Patient □ Office □ Other Fax Copy:
Rx Card Front/Back
Clinical Notes
Medical Card Front/Back Need By Date: **Patient Information Prescriber Information** Patient Name Prescriber Name Address Address City State ZIP City State ZIP Main Phone Alternate Phone Phone Fax Social Security # Contact Person NPI # Date of Birth DEA# License # □ Female □ Male **Clinical Information** Diagnosis: 🗆 M08.0 Juvenile Idiopathic Arthritis 🛛 H20.9 Uveitis 🖾 L40.50 Psoriatic Arthritis □ Other: Dx Code: Location: Joints:
Hands
Feet
Knees
Spine Other: Prior Failed Meds: Reason for Discontinuing: Length of Treatment: Length of Treatment: Reason for Discontinuing: Length of Treatment: Reason for Discontinuing: Drug Allergies Latex Allergy: $\Box\;$ No $\;\;\Box\;$ Yes Status: Weight 🗆 kg 🗆 lbs TB Test:
No
Yes □ New □ Restart □ Continuing Results:
Negative
Positive (please send lab results) Date:

		Prescription Information	Qty	Refills
□ Actemra®	162 mg □ Autoinjector □ PFS Vials: □ 80 mg/4 mL □ 200 mg/10 mL □ 400 mg/20 mL	Polyarticular Juvenile Idiopathic Arthritis Subcutaneous: Inject 162 mg SUBQ every 3 weeks (<30 kg) Inject 162 mg SUBQ every 2 weeks (≥30 kg) Intravenous: Infuse mg (10 mg/kg) every 4 weeks (<30 kg) Infuse mg (8 mg/kg) every 4 weeks (≥30 kg)	4 Week Supply	
		Systemic Juvenile Idiopathic Arthritis Subcutaneous: Inject 162 mg SUBQ every 2 weeks (30 kg) Inject 162 mg SUBQ every week (≥30 kg) Intravenous: Infuse mg (12 mg/kg) every 2 weeks (<30 kg)		
□ Benlysta®	200 mg Autoinjector PFS Vials: 120 mg 400 mg	 Inject 200 mg SUBQ once a week Load: Infuse mg (10 mg/kg) at weeks 0, 2, and 4, then every 4 weeks thereafter Maintenance: Infuse mg (10 mg/kg) every 4 weeks 	4 Week Supply Loading Dose 4 Week Supply	None
□ Cosentyx [®]	75mg PFS 150mg Pen PFS	 □ Load: Inject 75 mg SUBQ on week 0, 1, 2, 3 (≥15 kg to <50 kg) □ Maintenance: Inject 75 mg SUBQ on week 4, then every 4 weeks therafter (≥15 kg to <50 kg) □ Load: Inject 150 mg SUBQ on week 0, 1, 2, 3 (≥50 kg) □ Maintenance: Inject 150 mg SUBQ on week 4, then every 4 weeks therafter (≥50 kg) 	4 Week Supply 4 Week Supply 4 Week Supply 4 Week Supply	None
□ Enbrel [®]	50 mg □ SureClick [®] □ PFS □ Mini □ 25 mg PFS □ 25 mg/0.5 mL SDV	 □ Inject 50 mg SUBQ once a week (≥63 kg) □ Inject 25 mg SUBQ once a week □ Inject mg (0.8 mg/kg) SUBQ once a week (<63 kg) 	4 Week Supply 4 Week Supply 4 Week Supply	
□ Humira® Citrate Free	□ 10 mg PFS □ 20 mg PFS 40 mg □ PFS □ Pen	 □ Inject 10 mg SUBQ every other week (10 kg to <15 kg) □ Inject 20 mg SUBQ every other week (15 kg to <30 kg) □ Inject 40 mg SUBQ every other week (≥30 kg) 	4 Week Supply	
□ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.



Pediatric Rheumatology N-Z

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Need By Da	ate: Sh	ip To: 🛛	Patient 🗆 Office 🗆 Other	Fax C	Copy: 🗆 Rx C	ard Front/Back	🗆 Clinical N	otes 🗆 Medical	Card Front/Back				
	Patient In	form	ation		 Pre	scriber	nform	ation					
Patient Name				Prescriber Information Prescriber Name									
Address				Address									
City State ZIP			City State ZIP										
Main Phone Alternat		Alternate	Phone	Phone	Phone Fa:			-ax					
Social Security #			Contact Person	Contact Person									
Date of Birth		Fema	ale 🗆 Male	DEA #	DEA # NPI #		License #						
Clinical Information													
Diagnosis: M08.0 Juvenile Idiopathic Arthritis H20.9 Uveitis L40.50 Psoriatic Arthritis													
	her: : □ Hands □ Feet □ Knees		Dx Code:										
□ Ot	her:												
Length c		Length of	reatment:						-				
Drug Allergies		Length of	Treatment: Reason f					gy: □ No □ Yes					
Weight			□ No. □ Yes		Status:								
							□ New □	□ New □ Restart □ Continuing					
			Prescription	n Informati	on			Qty	Refills				
□ Orencia®	□ 50 mg PFS □ 87.5 mg PFS		 □ Inject 50 mg SUBQ weekly (10 kg to □ Inject 87.5 mg SUBQ weekly (25 kg 					4 Week Supply					
	□ 125 mg PFS		□ Inject 125 mg SUBQ weekly (≥50 kg										
	□ 250 mg Vial		 □ Load: Infuse 1000 mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (>100 kg) □ Load: Infuse 750 mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (75 kg to 100 kg) 					Loading Dose	None				
			□ Load: Infuse mg (10 mg/kg) IV at weeks 0, 2, 4, then every 4 weeks thereafter (<75 kg) □ Maintenance: Infuse mg IV every 4 weeks					4 Week Supply					
□ Rinvoq®	□ 1 mg/mL Oral Solution		 □ Take 3 mL by mouth twice daily (10 kg to <20 kg) □ Take 4 mL by mouth twice daily (20 kg to <30 kg) □ Take 6 mL by mouth twice daily (≥30 kg) 				4 Week Supply 4 Week Supply						
							4 Week Supply						
	□ 15 mg ER Tablet		□ Take 1 tablet by mouth once daily (≥					30 Tablets 1 Vial	None				
 Stelara[®] Psoriatic Arthritis 	□ 45 mg Vial (<60 kg)		Starter: Inject mg (0.75 Maintenance: Inject mg (0.75	mg/kg) SUBQ on week mg/kg) SUBQ on week 4,		eeks thereafter		1 Vial					
	□ 45 mg PFS (≥60 kg) □ 90 mg PFS (>100 kg with F	Ps)	 Starter: Inject 1 syringe SUBQ on week 0 Maintenance: Inject 1 syringe SUBQ on week 4, and then every 12 weeks thereafter 				1 Syringe 1 Syringe	None					
□ Xeljanz®	□ 1 mg/mL Oral Solution		□ Take 3.2 mL by mouth twice daily (10 kg to <20 kg)				4 Week Supply 4 Week Supply						
			 □ Take 4 mL by mouth twice daily (20 kg to <40 kg) □ Take 5 mL by mouth twice daily (≥40 kg) 					4 Week Supply					
	□ 5 mg Tablet		□ Take 5 mg by mouth twice daily (≥40 kg)					60 Tablets					
□ Other													

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